DOCUMENT RESUME

ED 084 012 PS 006 823

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TITLE	Covert Suicidal Impulses in Maternally Deprived Children.
INSTITUTION	Center for Preventive Psychiatry, White Plains, N.Y.
PUB DATE	69
NOTE	16p.; Paper presented at the Annual Meeting of the American Association of Psychiatric Clinics for Children (1969)
AVAILABLE FROM	Center for Preventive Psychiatry, 340 Mamaroneck Avenue, White Plains, N.Y. 10605 ($1.00)
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	*Case Studies; *Emotional Development; *Emotionally Disturbed Children; Mothers; *Parent Child Relationship; *Psychiatry
IDENTIFIERS	*Mourning

ABSTRACT

This paper discusses the development of suicidal impulses in children who have lost their mothers due to abandonment or death. The paper is based on two psychoanalytic case studies, in which the children were in therapy when the first suicidal impulses emerged. A pattern is described in which bereaved children's intense wishes to have their mothers back all to themselves are transferred onto the therapist. When these wishes are frustrated, suicidal intentions develop, are communicated, and can then be partially worked through. (DP)

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COVERT SUICIDAL IMPULSES IN MATERNALLY DEPRIVED CHILDREN

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For presentation: American Association of Psychiatric Clinics for Children
Annual Meeting, 1969

Retrospective studies indicate that certain psychiatric problems including suicide attempts, unsuccessful or successful, are more among adult patients who were bereaved of a parent during childhood than among non-bereaved patients. In this paper we give an anterospective point of view about the first emergence of suicide impulses in young children who are maternally deprived by abandonment or death and were already involved in a psychotherapy relationship, at the time of the first emergence.

The two children who are the focus of our data were psychiatrically ill as a combined result of their pathological mother-child relationship and the later pathological process of unresolved mourning for their mothers. The behavior of mourning for the purpose of this paper will be considered as "the totality of reaction to the loss of a love object."[1]

Both children were treated at the Center for Preventive Psychiatry. Most work at that Center is with children who are very young and with persons who have recently experienced situational crises such as death in the family which posed a risk to their mental health. Patients do not commonly come to us because they are attempting to destroy themselves. However, some bereaved children tell us of a secret wish to die, accompanied sometimes with a wishful plan to be reunited with the lost parent.

Bereaved children, especially in their hopeless loneliness, can experience hallucinations and other serious internal regressive efforts. They can also attempt self-destruction in their longing to be reunited with the lost parent. In this paper we indicate how the loneliness of two children and the frustration of their intense wishes to have mother for themselves was followed by the frustration of their wish for the therapist to become their mother. This facilitated the emergence, communication and to some extent the overcoming of their transient suicidal intentions.

The history and the treatment of the two young children presented in this paper may help us to better understand the triggering of suicide among adults who are orphaned during childhood. The findings are similar to those of Greer who reports that a separation from a new love object triggered suicidal episodes in a group of adult patients with a history of childhood bereavement.[2] It appeared that Greer's patients did not resolve the childhood object loss, and they suffered reactivation of incompleted childhood mourning upon experiencing the new loss.

The assessment and treatment tasks in helping bereaved children resolve the object loss has been delineated by Furman,[3] Kliman, et al,[4] and for adults (bereaved during childhood) by Fleming.[5] The following steps are suggested: assessment of the current developmental level, assessment of the developmental level at the time of the object loss, assessment of the character of

the pre-loss mother-child relationship, assessment of the child's capacity to retain object constancy, test reality, and to comprehend the concepts of permanence and death, general assessment of the child's capacity to progress in psychosexual, ego and superego, and drive development, assessment of the child's capacity to bear the painful process of affective release concomitant with testing reality of the object's absence. Furman suggests that in order for the child to comprehend the concept of death and to resolve mourning, the child needs to have mastered a high degree of ambivalence of the anal sadistic phase of relationships.[6] The literature and our experience indicates that this psychosexual phase may be even more difficult for the child to work through when the child needs to regress from achieved aspects of the phallic Oedipal phase, due to a parent's absence and the child's and the surviving family members' difficulties dealing with the internal and the external threats as the child and the family perceive them.[7, 8]

Our treatment goals include modifying or relieving psychological obstacles in the path of a child's maturation. We try to enable the child to mourn for the lost parent. As with the non-bereaved child, we try to help the patient shift from the pathological to healthier and more age-appropriate organization of defenses.

During the process of mourning, the child must endure painful feelings, both loving and angry, beyond the intensity and duration otherwise experienced by children.[9] Many need the support of adults. Not all caring relatives can provide this support. The child in psychiatric treatment has the opportunity of obtaining this support. However, as many of us have experienced, this can lead to both opportunities and problems for the patient. We know from adult patients who were bereaved as children (Fleming[10]) that the child's thoughts and feelings about the lost parent mostly possess the quality of the pre-loss parent-child relationship. Also, we know that the roles and the characteristics of the lost parent are transferred onto the therapist.

We recognize the latter phenomena as transference reaction. Furman states, "as the child decathects the representation of the lost object, he should have a new object that can be invested with some of his energy. . . Without such an object, he is in danger of developing degrees of identification with the lost object or hypercathexis of the self-representation that would impede his future development."[11] Similar reasoning suggests the advisability of assisting the child to mourn as soon and as carefully as possible following the loss, lest his unrequited loneliness and despair go underground or emerge openly beyond his capacity to endure. If unable to decathect the lost parent, the child's possible choice of reuniting through the action of suicide rather than by alternate mental processes of identification and hypercathexis of the self, carries great danger for the young child whose testing of realistic danger is faulty.

From a group of approximately ten children with suicidal ideation following object loss, we have selected two for the current report.

CASE MATERIAL

Case No. 1: Eric's first treatment experience began at four years ten months at The Cornerstone Nursery School, a division of The Center for Preventive Psychiatry. He was remarkably handsome and physically well developed. His upper middle class parents had been separated for one year. Eric was living

with his father, siblings and paternal great aunt. He rarely saw his mother. By the time we met him he had been discharged from two nurseries because of unmanageable assaultive and erotic behavior. At home he frequently wet his bed, had nightmares, infrequently set small fires and was generally sad. In short, he was a "little terror" to himself, his family and his community.

He was the third and youngest child of a tumultuous marriage which ended through divorce when Eric was four years old Eric's mother was attractive and self-centered, grandiose, with a dramatic flair. The father, well bred, well educated and professionally successful, was unable to interfere with the wife's use of the children for physical acts of erotic play. On the surface, he appeared as a stern man preoccupied with issues of law and order. He found life unbearable due to his wife's vagaries. These included her frequent departures, her inconsistency about taking or leaving the children while she was on professional work assignments, or on love and drug affairs. Consequently, he made a separate home for himself and his children without her.

Eric was described as a beautiful infant and young child—endearing, very active and very hungry. Feeding, as other experiences with the mother, was erratic. During toilet training at age two and three, he was encouraged by his mother and maid to exhibit his excretions and his genitals to them and visitors. He is said to have fondled his mother's breasts and genitals, and she to have fondled his. He is said to have observed her having intercourse with her boy friends. The family attitude toward Eric as a two and three year old was, "He cannot be stopped." This became his attitude toward the relationship with his mother and toward his libidinal and aggressive strivings. There was also a history of uncontrollable acts of self destruction in the father's family. The father's first mother drowned herself in the bathtub when he was six years old. This further determines Eric's reasons for panic in a bathroom. Two years prior to the father's mother's suicide, the father's paternal uncle suicided by cutting his wrists.

The wife of his uncle raised Eric's father, following the latter's mother's death. She also raised Eric for nearly a year, when his mother was so inconsistently available to him and for the period of time between the separation, divorce, and the father's remarriage. Eric's middle name is the same as his great uncle's. There was a general prophecy, as reported by the family, that this great uncle was incurably depressed, and no one seemed to be surprised when he suicided. Allegedly, Eric's father does not know of the cause of death and it is believed that Eric knows neither the true cause of the grandmother's nor of the uncle's death.

In Eric's mother's absence, he sought to establish other physically stimulating and erotic relationships with neighbor's children, siblings, and later with peers, Cornerstone School teachers and his Cornerstone School male therapist. After four months of treatment, and some moderate improvement, the father decided not to return Eric to Cornerstone for kindergarten, as had been planned. Eric, therefore, did not have the opportunity to work upon separation experience with the Cornerstone therapist. In the fall, just one week after beginning the kindergarten class in his local school, Eric's mother visited unexpectedly, with a boy friend decidedly younger than she. Alone in the house with Eric, the mother bathed him and stimulated his genitals. She knew and Eric knew that this visit and act was against the "new house rules." The bathroom once more became the place where Eric, as earlier

in his life, experienced erotic stimulation and perhaps Oedipal triumph. The following day Eric pulled down a female kindergarten classmate's panties. The school threatened him with dismissal. Since then Eric's mother has not visited him. She chose to perceive the psychiatric and legal recommendations that her visits be supervised by an agreed upon adult as rejection. There was no opportunity for the child to work through his difficulties with his mother. She never wrote to him, but did acknowledge the birthdays of her other children. Thus, Eric had even more reason to perceive his mother's disappearance as condemnation for his sexual thoughts and feelings and behavior with her. She is a living mother only in memory to Eric.

Eric returned to psychiatric treatment, this time psychoanalytic treatment, with a female therapist, just several days following the last meeting with his mother. Eric has been treated four times per week. At the time of the writing of this paper, he has completed twenty-one months of treatment and continues.

Eric experienced new shifts in his family life for the next two months. His father, as planned, remarried. His great aunt moved to her own home in the same neighborhood.

Eric, at age five years and eight months was introduced to a new style of family life and to a new quality of mother-child relationship. His father remarried a woman "different in character" from his first wife. "Mother-Norma," his stepmother, an attractive, intelligent woman, able to understand why Eric was such trouble, wants to be a good mother, knows and communicates rational expectations from the children including respect for one another, self-pride, appropriate self-control, and responsibility for actions within and outside the home. She brings a firm but loving quality of consistent mothering and shares an alliance with her husband in raising the children. The parents have been able to establish a therapeutic alliance with the therapist and collaborate with her through the "ups and downs" of Eric's treatment and psychological shifts.

Although Eric experienced considerable loving care from his stepmother, Eric continued to feel lonely. During treatment sessions, he was observed standing at the window, isolating his feelings and avoiding communication with the therapist. It seemed as though he was watching the people go by as though he had someone specific in mind. The therapist commented that he was looking for his first mother whose actual whereabouts were unknown to all of us. Eventually, he could verbalize memories of her, and in connection with these thoughts, he would climb in and out of the first floor treatment room window, go in and out the door, wanting to be chased and caught by the therapist. She interpreted to him that one aspect of this behavior was an attempt to establish the close physical relationship with the therapist just as he had with his first mother, "Mother-Barbara," who he now missed very much. Also, the therapist interpreted that another aspect of this behavior was his need to abandon the therapist as he had been abandoned by his mother, "that his missing-Mommy feelings made him want to run away from the therapist and to be caught by her." The stepmother was called upon for physical restraint when Eric needed it. The therapist explained to Eric that it was not good for his treatment work to be physically handled by the therapist, that Mother-Norma would physically help him to control himself, and the therapist would help him to understand his thoughts and feelings about his behavior. This

was done to permit the therapist to maintain analytic neutrality with this child. Often just "a look" from his stepmother or a comment such as "Your father would not like this behavior," was sufficient to enable the child to resume "private treatment work" without the stepmother's continued presence. External control was long missing from this child's life. Often we believe that he repeated this behavior to test the reliability of the prohibiting necessary controls of his stepmother.

Frequently the therapist's identification of the missing-Mommy feelings would throw Eric into a tirade and loss of control—throwing objects around the room at the therapist, destroying toys. He displaced his own sense of self-pity and helplessness upon Mother-Barbara. For example, he believed that she had "been kicked out" of their home. He would scream in her defense when referring to her "foolish behavior" (the treatment term for her erotic behavior with Eric), saying that "She never did those things," or, "She couldn't control herself." Not only did Eric feel, as we were to learn, that his foolish behavior had led to the divorce, but that he felt "kicked out of Mother-Barbara's life," and of his father's life since he remarried, and of his great aunt's life since she moved out of the home. The defense of displacement around such material was more definitively interpreted later in treatment. We believe that this work enabled Eric to talk more with his parents about his life with his first mother, about his fright during the episodes of physical excitement and about his lonely feelings during the parental separation. They explained to him that his first mother's behavior was the result of emotional illness, and they expressed concern about his past experiences. He was able also to accept their explanations as an explanation of his own behavior and mildly modified some harshness toward himself by saying at school, "I have problems."

Through fantasy play Eric would express his thoughts and feelings about the reunion with his first mother, generally including sexual involvement. The therapist connected to such play his wish for his first mother to return and his sad and angry feelings that she did not. A characteristic reaction to the therapist's comments would be attempts to assault the therapist. She directed the expression of such feelings to the treatment dolls and puppets. He would then bite their buttocks, color them red for blood, gouge their eyes and dismember their limbs, with excited affect. Then, as though gratified, he was able to stop such behavior and move on to more phallic-like play—buildings, roads, etc.

He tried to evoke abandonment by the therapist as he had experienced it by his first mother. His assaultive behavior to the therapist and his sometimes successful attempts to destroy valuable furnishings led the therapist to say: "It seems as if you want me to push you out of the room, as you feel your first mother pushed you out of her life." He questioned: "You're not going to kick me out?" Eric needed to repeat this play and similar comments were made by the therapist. This was apparently his attempt to mastery of the first and actual abandonment. He expressed a desperate sense of helplessness against the threat of being forgotten by the therapist when she took a one day or several weeks vacation. There was the same quality, no matter the length of time. He tried to write his name on the wall, took the therapist's telephone number and address, wanted to take toys with him or fill the treatment room box with extra supplies. He tried to write on her with a treatment equipment which had the brand name the same as his name. Another way of the dealing with this threat was in more subtle ways

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such as taking things and lying. Indeed his mothering experiences with his first mother were replete with deceptions. His repetition of her behavior was interpreted.

During the six months of treatment, Eric approached the therapist with an appearance of determined earnest sexual lust. His behavior was unlike the frequent teasing in the past. The motivation of bringing this material to the treatment was due to the acceptance of the parental prohibition against sexual play with his siblings, and the parents' demonstration of a quality of permanence in their marriage relationship. Also the longing for his first mother was acceptable to his stepmother. She could patiently support his feelings and listen to his reminiscing. Thus he needed less to ruminate about his first mother at home. Eric was helped to control his incestuous ideas toward his present mother by recognizing and accepting her mothering care of him. He responded with relief to her refusal on Mother's Day to accept an over-idealization of the mother and exclaimed, "I'm your mother. I am married to your father and here to stay. It's time you begin to live with that!" While he expressed ideas that a stepmother is more available than a biological mother by saying, "You can do sexual things with a stepmother and not the mother whose body I come from," he would refer to his stepmother as "my mother" and not "stepmother" or "Mommy-Norma," after the first six months of treatment.

As his siblings grew closer to his stepmother, and even though she was no less involved with him, his loneliness was increased. In order to sustain positive self-esteem he had to feel he was the favored sibling. The loneliness increased the need for sexual invitations to the therapist and thus to believe that he could be favored by her as he felt favored by his first mother, as his first mother favored her boy friends, and as he believed his father favored his present mother. The therapist commented upon Eric's verbal sexual invitations to her as partly a worry idea that every lady is a foolish lady and he wants to find out if she is one. She assured him that the therapist would not be a foolish lady as his Mother-Barbara and would not have sexual activity with him. At times this clarifying comment calmed him. At other times he needed to insist, "Oh, yes you will!" At home he was speaking less and less of his first mother, and by the end of the first year of treatment he gave her old presents to the Salvation Army. He would say often to the therapist, "Don't talk about her! The past belongs to the past." Remembering was painful for this child. It was painful for the family, as the father felt guilty about his relationship with his first wife and the consequences suffered by the children. The present mother did feel appropriately annoyed when she felt burdened in her marriage by these consequences.

The anniversary of the ending of his Cornerstone School work, which was not worked through at the time, evoked thoughts and feelings about his previous therapist. He called him "smelly." "I saw his grunty." Eric kicked the desk vehemently. He attempted to kick the therapist. The therapist commented that he felt as though his previous therapist had kicked him out of Cornerstone School because of his excited thoughts and feelings about the therapist. He would like to make himself better by kicking someone now out of his life. He called his present therapist smelly, "I can see your grunty." He smeared and messed in an excited aggressive manner. He invited the therapist to see his buttocks. The puppets attacked each other and were thrown away. This theme was frequently expressed in the treatment. He was thinking of times long ago when he exhibited his grunty to

his maid. Looking at hers and she looking at his excited him and made him feel that she was sexually interested in him. Sometimes there was a fight about making grunty. Now he is trying to act in the same way with the therapist. Another line of interpretation was that his concern about losing his grunty down the toilet was just a boy's worry that a person could be lost. When he thinks about losing Mommy-Barbara feelings, he thinks of it as losing his grunty, a part of his body. The therapist told him that his behavior, these thoughts about his relationship with grownups was not good for him and he often liked himself less for having them, as indicated by his worries that he could not be a daddy. In reality the children in the school and neighborhood would not want to play with him and invite him to their parties. Thus the anal aggressive behavior had masochistic and sadistic features. They were interpreted. As treatment progressed, this behavior was highly modified. He was growing healthier in his life outside of treatment. He sublimated anal obscene songs which he would still sing in treatment into original ditties. He excelled as a beginning piano student and gave a recital. His appropriate exhibitionism and sublimation were signs of more phase appropriate behavior—phallic-Oedipal and latency, although fluid and tenuous as yet. He was giving up the interest in being the "wild Jazz musician," as were many of his first mother's boy friends. He was not as interested in being a hippie but rather a good school boy, and interested in classical music, thus pleasing the expectations of his present mother. Once during treatment, the therapist smiled in reaction to a performance of one of his sublimated anal songs. He sang one after the other, improving. He often remembered the therapist's response and one would consider that it affected the phase appropriate behavior. He dealt with his knowledge that his mother had reported to me his excelling behavior, with shyness, also phallic-Oedipal.

Sad and regretful thoughts and feelings emerged regarding the sexual play with his mother and his siblings in the past. This was frequently followed by inviting the therapist to look at his buttocks, by disruptive messy behavior in the treatment room. It was interpreted that he felt guilty about his long ago sex play and that his young mind did not enable him to understand that this was not good for him. There were frequent "yells for help," which could be heard throughout the building as an attempt to engage the attention of the men, who he named, to stop his excited play. This led to an interpretation of the displacement demonstrated in the treatment, as a wish for a disappointment that his father did not stop him or the others. He decided that he did want to grow up to be a big and tall man. He stood on tables in the treatment room smiling and grinning. But he said that he did not expect to be a daddy and was sad about it. He could not exhibit his accomplishments to the therapist and frequently regressed to phallic-Oedipal like behavior to anal-sadistic behavior. It was interpreted along the lines that he believed that the only good parts of his body are the back parts and that the front parts are not good because he did sex play. Since his mother did things with him as a little boy that he thought were over exicting and not good for him, he might believe that there was some danger in becoming a big boy. Just as he thought that he did not have good front genital parts to exhibit, he thought that he did have some good work of his mind to exhibit to the therapist.

For many weeks he persistently played war games during treatment. Friend and foe easily exchanged roles. Limbs were easily lost in automobile accidents, by gunshot. It was clear at one instance during his treatment that he was angry with his father for being away at that time on a vacation with his

present mother. Even though he was staying in his own home with a very adequate maid and relatives, he was very lonely. He asked the therapist quite seriously, "Why do people have wars? Why does one country always want to take away the land of another country?" He immediately went into more play and avoided the therapist. She acknowledged his interest but was aware that he was not ready to think about and to answer these questions because the war was an Oedipal war, and because he simultaneously indicated his worry about castration. Gradually the therapist introduced the idea that one of the worries about being a big boy was that he would be excited and want to be involved in a war, perhaps a war with his father. But not knowing whether his father was friend or enemy, he could not be sure that he would not be wounded or lose a part of his body in the competition with his father at various aspects of his life. Such interpretations were made whenever the opportunity arose such as skiing, giving presents to his mother, but particularly when they were out of sight on one of their vacations.

Indeed he was a very lonely boy and one could well understand why the continuing theme of his play was a drama about "lonely boy." The game itself changed as he had more ego accomplishment of speech, building scenery, etc. The therapist was assigned a role in the play which was identified as a treatment game. She was generally the character who could say what will happen to the other characters and often could predict the future. Eric created an often repeated character who he played, "the one-eyed monster who could not be controlled." Eric had a temporary symptom during this era of his treatment, an eye tic. Not even the police could stop the one-eyed monster from hurting others. There was a ghost who sought revenge upon the lonely boy because the lonely boy looked for help and obtained it from the police. The therapist identified the ghost as a symbolic representation to Eric and the ghost could be a representation of his lost first mother, whom he feared would seek revenge by injuring because he needed the help of his stepmother and loved her so much. At a later date the interpretation included the fact that he had expressed loving feelings for his therapist by the look on his face frequently and realized that his analysis was helping him to get along better with his family, his school and to become more popular with his friends. He became curious about the therapist's personal life, needed to see her as a child, as he was, thinking that one of the male therapists who physically resembled his father, was her father. There was no expression of fantasy about her own family life. He became more openly curious about his mother's and father's love making and could accept that he needed to think about ghosts at night to keep him company, to at least think that he in some way was with his first mother as his father now is with his present mother. He was able to acknowledge bed wetting, however, more to the maid and not to his mother, and to talk of his night fears. The bed wetting and night fears were interpreted as connected and the expression for the jealousy that his father was with his mother and the excitement he felt in his own body about loving a grownup lady. Within several days the bed wetting stopped and did not recur. He no longer needed a night light, and said he was less afraid.

Themes of treatment were consistent and more readily synthesized and can be traced to the expression of his suicide intentions. Violent erotic and aggressive play with the puppets was followed by Eric spontaneously telling the therapist that he once killed a pet bunny by dropping it from his first mother's apartment terrace several stories high. The incident occurred when he was three years old. "But, I didn't really mean to kill him. I loved my bunny," he said with sadness. He told me that his first mother had given him

the bunny for a present during the time they were living together away from the father. He then became messy, assaultive and destructive in the treatment. He expressed pity for his first mother, "She could not help herself, she was sick." The therapist told him that he also was "too young to know that the sex play was not good for him and that he had guilty feelings about it. He looked at the therapist wide-eyed, "You mean I couldn't know better?" The acceptance of the explanation about his helplessness against impulses provided release of an inordinately harsh self-criticism regarding the need to gratify his loneliness with erotic behavior and relationships. But he had not developed sufficient self-criticism and observation of erotic play with friends and his present mother was maintaining a close watch over his social life and was in constant contact with the teacher around his behavior in school.

During his fifteenth month in treatment and one month before his seventh birthday, he began to play roles of a pilot, an engineer, an important scientist doing experiments, a doctor, and indicated a tremendous increase in verbal expression. He decided with the therapist that his treatment birthday gift would be a doctor's kit. He received this gift as acknowledgement of phallic capacity and displayed a look of obvious love for the therapist. He then shifted immediately back to overly excited, messing and destructive behavior during the session and there were frequent episodes for several days of such behavior at home and at school. Puppet play during the sessions involved intercourse simultaneous with violence and body damage frequently. He announced, "I'll have intercourse with you!" The therapist told him that "you want to make love with a big lady as your Daddy does with a wife." Also she told him that since the therapist recognized with him that he was growing up and now had another birthday since she first met him, that he is afraid that the older he gets as a child, the stronger the wishes will be to have the therapist as his wife and do sexual behavior with her. The therapist's suggestion that one day when he grows up he will have a lady his own age to love, to marry and have children with did not interfere nor stop this behavior. He very seriously invited the therapist to have intercourse with him. He became grossly sad at the therapist's refusal. She noted to him that his first mother had actually led him to believe that this was possible, and that he is now disappointed in the therapist for refusing him.

During the eighteenth month of treatment he received a postcard from his first mother stating that she was going to be married. He grew more markedly sad and agitated in the treatment work. One day he was observed gazing out of the window. Then he turned around saying, "She's never coming back, I can never marry her." He was truly emotionally pained with disappointment and sadness. His eyes were moist. He had expected the reality of the status with the mother. The therapist recognized with him how painful the disappointment was. He then played puppets, mother and son, and they violently caressed. Father puppet injured the boy puppet, threw the boy out and then murdered him. The boy puppet then did the same to the father puppet. The mother puppet and the boy puppet went off to the woods together. Father puppet followed, sought revenge by killing both. Eric said to the therapist quite sadly and seriously, "I can go to the woods and wait there until I grow up, and Mother-Norma will come there and marry me?" He was appealing for some element of hope. The wish and expected disappointment, known partly in his head and partly in his heart, was commented upon. He became angry with the therapist. He pointed to his genital area, saying, "They're small and puny; my father's are big." Puny-boy thoughts and feelings were connected to those he had upon seeing his father's larger genitals when his father was undressed when he was a much

younger boy. At the time all he had been able to think about was not being old enough for his mother, as his father was old enough for his mother. He did not understand that "in time you will grow up and then be big enough for a lady your own age."

Eric became increasingly demanding for oral gratifications in his sessions as in his early treatment days. The connection of the present feelings in treatment were identified as feelings he had experienced at other times, early in his treatment and his life as a little boy with his mother. He attempted to destroy the other patients' treatment work, was assaultive to the therapist and antagonized again and again in the hope that he would be dismissed from treatment. He was trying to be "tough," "the boss," words his father had used about himself. He threw out his therapist and wanted to assault her as he had once observed his father having intercourse with his first mother and physically hurting her at another time. The therapist told him that throwing things at her and saying his Daddy's words was his way to show her that he wanted to be to her big and tough like a grown man as his father had been to his first mother. He went into the lavatory for several minutes yelling, "Come and get me!" He was excited and seductive. He seemed to want the therapist in the lavatory as he once had his mother, and this was explained to him. He teased, "I'm in the bathtub now!" Later in the treatment room he openly proposed to the therapist, "Will you marry me?" He was now consciously in love with his therapist and wanted her to be his wife. She told him, "You have loving feelings now for me and it is very disappointing when you realize you cannot marry me." He was frustrated, ran to the lavatory and said, "I have to go now." He returned to the treatment room, excitedly touching his penis through his trousers and saying, "I touched my penis. See?" The therapist asked him what he wanted her to see. He repeated, "See my penis, see my penis." The therapist said that he also wanted to know from her whether the touching of his penis had hurt it and whether it was still a good penis. He giggled in response. The following day he left the treatment room to go to the lavatory. He was giggling and laughing. When he returned to the treatment room he at first teased, and then quickly actually revealed his penis saying, "See my penis." The therapist said, "You want to show me your penis because you are worried, you want to know from me if it is a good one, you want to know from me if it was hurt by your foolish behavior with your mother, perhaps with her in the bathroom." Sadness resumed and continued. A few days later he locked himself in the lavatory, sounding as though he was terrified to come out. He said that he had climbed into the tub and that he was going to jump out of the window, which was two stories high. The Director was summoned as the situation was realistically dangerous. With the Director's presence apparently helping him, Eric opened the door. Eric said to him, "Will you open the window so I can jump out?" The child was extremely sad and forlorn. Surely Eric knew that the twenty-foot fall could hurt him. The Director replied, "What kind of friend do you think I am?" Eric remained aloof from the therapist for several sessions. He tried to climb out of the second story treatment room window several times after that, once saying that he wanted to kill himself. He checked repeatedly to see if we had put on the locks on the windows as we had said we would to help protect him. No similar behavior was reported at home. The parents were told of our concern. They were supportive and took similar precautions in the home. The therapist interpreted to Eric, in various ways, that he felt frustrated because he could not be her special boy, or lover or husband. The guilty feelings, the lonely feels and puny small boy feelings all together made him want to kill himself. Within a two-week period he became more alert and happy. He returned to a vigorous theme in the treatment of being a scientist and explorer. The psychoanalytic treatment

continues.

Case No. 2: Lonny entered psychoanalytically oriented treatment one time per week at the age of seven, one year and five months following her mother's sudden death. Lonny was an attractive seven-year old girl whose large size and excellent ability to put her feelings into words led one to think of her as a much older child. Her presenting problems—difficulties in learning school work, nightmares, easy frustration, high demands for individual attention, thumb-sucking and over-eating—indicated severe unevenness in her psychological development. Her maternal aunt, who was caring for her said, "Lonny wants a mother so badly it hurts."

The aunt, an articulate psychologically sophisticated woman, was able to give a good deal of history about Lonny. But, it was prejudiced by her ambivalent feelings toward her late sister and toward the care of this very needy child. Lonny was the only child of her mother's first marriage and her father's second. The father's first wife had died of a car crash and left him with the care of two very young boys. There was considerable conflict between the children of his first marriage and Lonny's mother. She had married a man many years older than she so that she would be cared for and in order to have a child. She was overwhelmed with multiple responsibilities. The marriage was hectic. A long separation occurred when Lonny was three years old. Then the father had gone overseas on military duty. At that time the mother turned more to Lonny and to her accomplishments for gratification.

Lonny's mother was treated for a cardiac condition several years prior to her marriage. She had a "heart attack," and was told that if she had another it would probably kill her. She did not tell the complete story to her husband, did not let it deter her from having a child, neglected her physical health even when she became quite symptomatic one month prior to her death. The family aware of her symptoms did not force her to have medical assistance. During that month she became inordinately punitive toward Lonny, even to the point of striking her in a restaurant. Prior to this she had treated her with inordinate approval, allegedly making few clear references to right and wrong to the child. The mother herself could not do right for herself even to the degree of having the necessary medical care.

Lonny's mother's death was sudden and took place in the bedroom. Lonny was playing outside. She was not permitted to come to the closed bedroom doors to see her mother. The family could not answer her questions about how her mother died, could not permit her to see the mother's dead body, as well as to permit her to attend the funeral. The child persisted in this request saying that it was important for her, obviously attempting to establish the reality of her mother's death. The family burdened by their own grief and difficulty in recognizing the reality of this young woman's death and the bereavement of this young child, supported the child's tendency towards ambiguity and difficulty in "learning" in school. The family admits to having been frightened and upset by her requests, and the persistent ongoing request to visit her mother's grave. She did not attend the unveiling of the monument either. They have also been unable to discuss with her, despite her persistent questioning, the causes of her mother's death. They did not agree to an autopsy to clarify the actual cause of death. Here, ambiguity tends to meet their own guilt most likely for not forcing the mother to obtain medical care and to face their own anger and disappointment in her

Following her mother's death Lonny was sad and talked openly of missing her mother. She made such statements to her father and aunt which frightened them, such as, "God is not a good god or else he would not have taken my mother from me." "Why didn't we all die with her?" "It isn't fair that we were left on this earth alone." She seemed aware of her father's loneliness and his sense of helplessness in dealing with these thoughts. She grew disappointed in her aunt and father as later revealed during the treatment work. The father slept with her in the bed to ease "her night fears." She was subjected to other object losses, her maid, her sister through marriage. She made frequent visits to her maternal aunt's house and indicated improvements in her organization, school work and moods when she was there. This led to her actual moving into the aunt's house. She thus left her father as she had been left by mother, left the threat of taking the mother's place as the only female left in the house. Her aunt, divorced and the mother of two teenage children could provide consistent and regular care. There was mild improvement. She complained that her father did not spend enough time with her, although he was with her every evening. This feeling was related to the father actually spending more time with the aunt than with her, and the father in not directly dealing with her expressions of interest and feelings about her mother.

It took one year for the family to complete their application for preventive help, giving multiple excuses for this. They probably recognized that dealing with Lonny's problems would mean dealing also with their own. They expressed no angry feelings towards Lonny's mother other than exaggerated criticism of her indulgent handling of Lonny. This was the only way they could express the burden they felt. As they expressed these criticisms in front of Lonny, it also led to further feelings of loss, that she had not enjoyed good mothering when her mother was alive.

Lonny felt truly alone both in the wish for her mother and in the establishment of her mother's death. A powerful factor in the family is that of deception. For example, the mother's facade of her illness, never directly telling Lonny that her older siblings had a mother who died of a serious illness, and letting themselves believe that Lonny did not know this. The siblings were nearly ten years older than the parents' marriage and the mother would have been twelve had she been the biological mother of the oldest sibling. Lonny actually presented a symptom during treatment of not being able to add correctly with the figure twelve. One of the greatest deceptions was the reference to Lonny as "the baby." She looked more ten years old than seven years old and had the precocious verbaly ability of a ten-year old. But she easily regressed and was then criticized for acting like a baby. The family was critical of this behavior. The family brought the deception into the treatment. For a long time, they did not tell the therapist that the child was regularly seeing a rabbi for some mystic spiritual help and that the aunt and father were having an affair, and that the aunt was not divorced but separated for many years from her husband. While she and her brother-in-law had talked of marriage, they wanted to believe that Lonny knew nothing about this.

Lonny deceived people as she hoped to deceive herself. She deceived people as she felt she had been deceived. For example, she communicated to teachers and classmates occasionally that she did have a living mother. She told little lies to her aunt about assignments, and no one ever knew who was at fault when Lonny had a fight with one of her cousins or siblings. Surely Lonny knew but needed to deceive.

In her first session Lonny said she had nightmares which she believed started at age three. She thought this was a parapraxes and said, "Oh no, I mean five." She dreamt very often of a man with a light bulb for a head, or a light bulb on top of his head. The father was bald. She cried out, woke up and called for her aunt's help after such nightmares. The company of an adult comforted her. She stated a wish for help with these fears. When the therapist acknowledged in the initial session, which had been acknowledged to the child as a consultation session, that she knew that Lonny's mother had died, the child looked quite sad. Tears came to her eyes and she said, "I miss my mother. She told me that if I wish upon a star my wish will come true. Every night I wish upon a star that my mother will come back, but she does not." The therapist commented that Lonny must feel disappointed when she thinks that her mother is dead and that her mother said something would come true and it does not. Tears again came to Lonny's eyes and she said to me, "Sometimes I have other thoughts." With some hesitation she continued, "I am going to jump off a cliff. I will die. Then I will be with my mother and I won't be lonely anymore." The therapist told Lonny that she recognized how desperate she felt. She agreed with Lonny that she needed the help of a specialist outside of her family to also help her with these worries. At the end of the first appointment Lonny looked up at the therapist and said, "I've been looking for someone like you for a long time." We recognized that Lonny was telling the therapist that for the past year she had been expecting some help. There was an underlying meaning which was probably not yet within her conscious understanding. She was looking for someone to whom she would be very special and who would help and relieve her other frustrations, as her mother did. It was in association to the finding of a new person, the therapist whom she had waited months to see, that the suicide impulses were first communicated. They had indeed developed during the time Lonny expected help.

The treatment was even more difficult to carry out than with Eric, for several reasons. There was little therapeutic alliance with the family. They wanted relief from the burden of caring for Lonny. But at the same time were not receptive to any guidance work which would provide such relief. The treatment was felt as a demand, a financial demand, a time demand, as well as a threat that they must face some of their own feelings. There were frequent complaints about the therapist, even to the point of taking them to the medical director. They wanted the therapist to feel guilty for the burden that she was placing upon them, which were realistically not a burden. Thus, they transferred onto the therapist the feeling which they had towards Lonny's mother. The therapist's interest in Lonny was seen as harmful by the father. He transferred to the therapist the negative view he had of his wife's rearing of his children from his first marriage and of Lonny.

Lonny came energetically for her sessions. The first few times she drew pictures of her family and talked about the additions to and subtractions from the family. She communicated problems in arithmetic in school, particularly in the areas of addition and subtraction. She was able, with help, to make a conscious connection between this arithmetic problem and the problems she was feeling in the additions and subtractions of people in her family. Within a two-month period of treatment and more organized help by her aunt in doing her homework, there was a gradual improvement in the arithmetic. Other treatment work included engaging the therapist in arts and crafts, identifying that it was work she had done with her mother. She tried hard to be what one might call a good girl, and she tried to be carefully controlling of thoughts and feelings that she had previously communicated to the therapist

at the consultation session. The therapist reminded her that she overheard that after that session the child saying to the aunt, "I think she likes me." The aunt said, "Wait til she gets to know you. She won't like you anymore." Then the aunt denied to me at a later date that she had ever made that statement. The therapist connected to the child that she would be afraid to show the sad and angry feelings toward the therapist, as she was afraid that I might send her away.

Considering the family's ambivalence in permitting this child to continue consistently in treatment, it was considered best to inform them of the child's interest in suicide. They were shocked and denied having any such knowledge of her interest expressed at home. We believe this to be true. But the conscious shock was not enough to prevent emergence of efforts to withdraw this child repeatedly from treatment. Chronic lack of adult support and lack of hearing the child's "cry for help" led us to be increasingly concerned about her well-being. At one point when Lonny was withdrawn from treatment for two weeks and urged by her father to tell her aunt who did want her to be in treatment, that she did not want to continue. Feeling abandoned, she said that she did not want to return to treatment. When the father agreed to this, she became sad, withdrawn, thumb-sucking at home more and demanding more food. When the therapist next saw Lonny and asked her about her former thoughts and feeling lonely and wanting to die, she reported that during the absence from treatment, "the thoughts came back." She was able to admit anger towards the therapist, who could not see her in the evenings nor on Saturdays, at the hours the aunt and father wanted her to be seen. She transferred onto the therapist the feelings of being disappointed and abandoned by a grownup. It was interpreted that the therapist was thought of as having provided another deception, an implied and broken promise of continuing care. It was as though she seemed to think that every grownup lady was going to treat her as her fantasies led her to believe her mother had treated her, by abandoning her as she had died.

When treatment resumed it was soon necessary for the therapist to cancel to attend a scientific meeting. The child's fantasies indicated that she thought the therapist who was quite firm about the child's keeping appointments, was now abandoning the child from this commitment to have entertainment for herself. Lonny's low self-esteem was reflected in the thought that she would be abandoned by the therapist. She tried to camouflage feelings about any separation from the therapist, would frequently deny them. After eliciting the fantasies and discussing them, the therapist told her the real reason why she would be at a particular session and the child actually forgot—utilized the fantasies fo explain the separation.

Lonny continued to work in treatment with games and puzzles, trying to get the therapist to guess facts and answers. The game had a quality of secrets known only to Lonny. She seemed to enjoy teasing the therapist by not providing the answers. It was commented by the therapist that the puzzle play was like trying to piece together her own thoughts and feelings about what really happened in her own family, especially about the death of her mother. She was looking to the therapist to give her some of the answers as there was a growing feeling that perhaps the therapist could be an honest lady.

There were frequent interruptions in her therapy but she continued to work with the therapist in consistent themes. At the time of Lonny's departure for her family vacation which occurred during the six months of treatment and

in anticipation of the therapist's vacation one month later, she developed a new symptom, stealing money and other inanimate objects from her siblings with whom she had rivalry for the love of the mother substitute. She felt deprived by the therapist in not receiving a treatment birthday present, also. It is interesting to note that the aunt's child who was blaming the thefts on her had once had treatment for a similar symptom when his father left the home. While the aunt was intellectually able to understand the reasons for the symptoms, she could not directly deal with them and attempted to deceive the therapist by waiting until the very last minute literally before the child left for the vacation to tell the therapist. It was again to make the therapist unable to help the child and thus to relieve the aunt of her own guilt that she could not help Lonny as much as she wanted to, and to be not only the perfect aunt but the perfect mother for her. It appeared to be that taking the things which were stored away and to take the money which was not used to buy anything, was a way of consoling her lonely feelings and the insult against her self-esteem that she had experienced at the time of a separation, perhaps. We became aware that the new symptom was taking the place of the suicide intentions. Lonny denied them during the session but quietly listened to the therapist talk about the reasons why a child takes things. While lying continued, the taking things stopped.

Lonny did not expect the therapist to return following the therapist's summer vacation even though she had in her hand an appointment for the fall. The anticipated disappearance and abandonment which she now expected from the therapist were connected to the thoughts and feelings she had about her mother's disappearance. The anniversary of her mother's death was just two days before she had her first appointment. She wanted to take treatment toys with her during the last session to keep with her over the summer vacation. The therapist and she agreed that this was a way of helping her diminish the lonely feelings that she would have in missing the therapist and to maintain some kind of closeness with her. It was notable that she had difficulty in recognizing "mine and thine" and to recognize that the therapist would not be in collusion with her in her deception of other child patients. She said, "They won't even know I was taking the treatment toys if you don't tell them." Her hunger, her desperation and strong sense of loneliness made it difficult for her to recognize the necessity to share treatment toys, or to recognize that the relationships within her family could suffice over the four-week interruption in treatment. Since Lonny had had so many experiences of interruption of treatment and knew that her family could not deal with their own feelings about the mother's death, perhaps she suspected what actually did happen to her treatment in the fall. While the appointment was accepted, the morning of the appointment, the aunt cancelled, saying that she did not know how Lonny could get to the appointment at that time, nor at any week at that time, with full knowledge that it was the one hour the therapist had to see the child. However, we were again able to work through the aunt's difficulties and her side of "good guilt," made her able to make arrangements for the child to continue in treatment. Treatment continues.

SUMMARY AND DISCUSSION

We have described anterospectively the development of or first communication of self-destructive impulses and acts in two children as part of their reactions to maternal deprivation. There appear in these children familiar combinations of simultaneous urges to destroy oneself and reunite with the ambivalently loved lost object. The data presented also suggests a new hypothesis for understanding stages in the development of suicidal behavior. The new hypothesis elaborates and supplements the well established concept that object loss in adult life reactivates guilt and depression over prior object loss experiences, thereby increasing suicidal behavior. The data indicates that at least during childhood the acquisition of and vicissitudes of a new relationship, rather than only the loss of a new object, may reactivate the child's prior loss experience. The phenomenon of suicidal impulse upon finding a new love can be best understood by postulating that in the transfer of libido and aggression from the old ambivalently loved object, a special risk occurs. A risk is that the new object will be perceived as bound to repeat the prior loss. Further, because of the special nature of transference phenomena, a treated child will experience the treatment relationship in terms of the old one. The old relationship included a distinct breach and therefore the new one is experienced as including a distinct breach of attachment, with all the attendant pain and despair appropriate to the historic loss. Successful acquisition of a new love object also leads to guilty reactions which are previously invisible. We hope it is clear that reactivation and compulsive repetition of the prior despair in the transference not only occurs but is dangerous and difficult to manage at moments, particularly with poorly integrated children. Yet, it offers unparalleled opportunity for interpretation of and working through of dangerously charged emotions and repetition compulsions of children who have until then lived in covert and unshared pathological despair. The risk is probably far less than that of later life suicide in similar children.

Eric and Lonny both illustrate a common paradox which is also a major public health problem. Divorced and bereaved families' children have more problems in certain respects when a remarriage occurs than when it does not occur. Gregory's anterospective study of thousands of Minnesota school children revealed that when remarriage occurs, one parent children have higher incidence of school year failure, school drop out and multiple arrests compared to bereaved children in non-remarried families of similar socio-economic and racial backgrounds.[12]

Why is it that maternally deprived children like Eric and Lonny—although provided with substitutes for their mothers—and even with a therapeutic female object—did not improve automatically? Perhaps by understanding their turmoil we can gain further understanding of the mental health problems precipitated upon parental remarriage.

Only by a large scale study could we hope to know whether the evoking, interpretation and working through of suicidal impulses by the treatment process in childhood is—as we predict—regularly associated with good clinical effect and lowered incidence of adult suicidal tendencies and other problems. A control, untreated or differently treated group of similarly deprived children would be required for a full assessment of this important preventive task.